Pain Treatment Associates, LLC **Print Patient name: _____DOB:_____**

Your Pain Management Specialists •1410 Doctors Drive •West Plains, MO 65775 Phone: (417) 256-BACK

TREATMENT AGREEMENT

By INITIALING each of the entries and signing at the bottom of page two I agree to comply with the following:

Initials↓

_____ 1. I understand that the main treatment goal of Pain Treatment Associates, LCC (hereafter known as "PTA") is to improve my ability to function and/or work. In order to have the best chance for pain relief and best outcome I understand that PTA may recommend certain interventional treatments. I agree to consider all recommended treatments and to participate in rehabilitation as indicated, as well as follow better health habits, specifically involving exercise, weight control, tobacco usage and alcohol consumption (which may endanger my health if taken in conjunction with certain controlled substances). I understand that only through following an active, healthy lifestyle can I hope to have the most successful outcome from my treatment.

_____ 2. I understand that PTA only employs fully licensed, trained and qualified medical providers and that I may be scheduled with different providers, including a Family Nurse Practitioner, as deemed appropriate for my treatment plan.

_____ 3. I understand that I must make every effort to keep all scheduled office visits and procedure appointments at the appointed time. I realize that a total of two (2) NO SHOW appointments (including failure to appear on time) is grounds for termination of care from PTA.

_____ 4. I understand that PTA utilizes toxicology (lab) screening to test for the presence of both licit and illicit drug use and that I will submit urine, saliva or blood samples upon request.

_____ 5. I understand that I will disclose all prior pain-treating physician(s) and the nature of the treatment(s) to PTA. Additionally; I will disclose all medication(s) that I am currently taking or have taken within the past two weeks, including the use of street drugs. Any historical data as reported by the patient that is inconsistent with lab evidence will be considered as dishonest and will be grounds for termination of care from PTA.

_____ 6. I understand that I shall not use illicit ("street") drugs including, but not limited to, marijuana, meth, and crack cocaine. I also agree to not be in the presence of anyone using illicit drugs. I understand that lab evidence consistent with illicit drug use is grounds for termination of care from PTA.

_____ 7. I understand that PTA takes very seriously the prescribing of controlled substances (i.e. sedatives and narcotics). In that regard, I will not distribute, sell, lend, rent, or give any of my medication to any other person, nor will I take another person's medication. I realize that this type of behavior is against the law and will result in termination of care from PTA.

_____ 8. I understand that I shall not request nor accept controlled substance medication(s) (sedatives or narcotics) from any other physician or individual while I am receiving such medication from PTA (also known as "doctor shopping"). In addition to being illegal, it may endanger my health to take additional narcotics or sedatives in excess of what has been prescribed. In the event of an emergency (i.e. ER visit/Urgent Care visit), I will notify PTA during normal office hours to report the administration of additional controlled substance(s). I understand that "doctor shopping" is grounds for termination.

_____ 9. I understand that if I am receiving prescriptions for controlled substances from PTA then I may be called in for random pill counts and toxicology screening to ensure proper compliance with the prescribed medication(s) and to rule out illicit drug use. If called in, I agree to report to the PTA clinic **within twenty-four (24) hours** of my notification. I may be called at any time and I expect to be billed for the appointments and any related lab tests. I realize that failure to comply with a random pill count request is grounds for termination of care from PTA.

_____ 10. I understand that I am to keep PTA informed of any phone or address changes. If I am prescribed controlled substances, PTA must be able to contact me and I will notify PTA if I will be unavailable for more than any twenty-four (24) hour period during weekdays (M-Th). I realize failure to comply with this request is grounds for termination of care from PTA.

OVER PLEASE

TREATMENT AGREEMENT *continued*

_____ **11**. **I understand that I am responsible for my controlled substance medications, if prescribed.** I will not take more medication(s) than prescribed unless it is approved by the physician. **I understand that I must keep track of my medication(s) and plan ahead**. **REFILLS WILL NOT BE MADE IF "I RUN OUT EARLY".** Refills will **NOT** be made at night, holidays, or weekends. If the prescription or medication(s) is lost, misplaced, stolen, or if I use them up sooner than prescribed, I understand that they will **not be replaced and may be grounds for termination of care from PTA**.

_____ 12. I understand that **I am to bring ALL medication(s) prescribed by PTA in their original containers to EVERY appointment in the office (excluding procedures at the ASC).** I realize that failure to bring such medication in their bottle(s) to **every** visit constitutes non-compliance and is grounds for termination of care from PTA.

_____ 13. I understand that in the event that I must reschedule a prescription refill appointment I shall attempt to reschedule to a time in advance and not later than my original appointment so as to facilitate a pill-count. I understand that a total of two appointments at which I do not have pills to count is grounds for termination of care from PTA.

_____ 14. I understand that if my controlled substance medication is changed, I may be requested to have the remainder of the old prescription medication destroyed in the presence of PTA staff. This act will be documented in the medical record and I agree to sign as a witness to the destruction of the medication when indicated.

_____ 15. I understand that I will provide PTA with the name(s) of the pharmacy (ies) I use and I will only fill controlled substance prescriptions at the pharmacy I designate. I agree to notify PTA if I need to change pharmacies.

_____ 16. I understand that pursuant to applicable billing laws, I will be expected to pay relevant co-pay charges (including Medicaid) at check-in on date of service.

_____ 17. I understand that belligerent, combative, erratic, and non-compliant behavior toward any member of the PTA staff will not be tolerated and is grounds for termination of care from PTA.

_____ 18. I understand that dishonesty in any form is grounds for termination of care from PTA.

_____ 19. ***(FEMALES ONLY)*** I understand that if I am pregnant, or if I become pregnant, I will notify PTA. I realize that interventional treatment utilizing x-rays will need to be postponed and that weaning from controlled substance medication may need to be undertaken for the safety of the developing fetus.

I have fully read and understand what I have initialed on both pages of my agreement. I understand that Pain Treatment Associates, LLC holds the final decision as to the determination of non-compliance. Non-compliance will result in termination from all PTA services.

PLEASE NOTE: Prior to being accepted as a patient at Pain Treatment Associates, all individuals will be notified as to whether or not they are approved for an in-office evaluation after a thorough review of past medical records, completed forms, and questionnaires. Appointments must be kept and this treatment agreement must be followed in order to continue as a patient, once established.

Pain Treatment Associates reserves the right to update, modify, or delete any portion of this agreement at any time without prior notification.

_____ _____ _____/_____/_____

Patient Signature Patient Name (**Print)** Date